DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 15, 2022

Administrator
Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN 56164

RE: Project Number(s) SL30347015

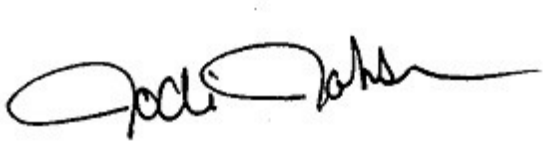
Dear Administrator:

On September 9, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 10, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,



Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Electronically Delivered

July 21, 2022

Administrator
Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN 56164

RE: Project Number(s) SL30347015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 10, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = $500
St - 0 - 1750 - 144g.71 Subd. 7 - Delegation Of Medication Administration = $3,000
St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services = $3,000

The total amount you are assessed is $6,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 507-344-2730 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30347015-0 On June 6, 2022, through June 10, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 17 residents, all of whom received services; under the provider's Assisted Living license. On June 6, 2022, an immediate correction order was issued for SL30347015-0, tag identification 2310 at a level 3, isolated (G). On June 6, 2022, an immediate correction order was identified for SL30347015-0, tag identification 1750 at a level 3, widespread (I), and was issued to the licensee on July 15, 2022.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250		

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0 250	Continued From page 1 (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04;	0 250		

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0 250	Continued From page 2 (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6. 2022, at approximately 9:18 a.m. licensed assisted living director (LALD)-A stated the licensee's	0 250		

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0 250	Continued From page 3 employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone	0 250		

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0 250	Continued From page 4 conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes	0 250		

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0 250	Continued From page 5 indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 250		

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0 250	Continued From page 6 licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. As a result of this survey, the following orders were issued 0510, 0660, 0700, 1370, 1380, 1440, 1470, 1530, 1620, 1650, 1700, 1710, 1730, 1750, 1830, 1890, 1910, 1940, 1950, 1970, and 2310, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:	0 470		

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0 470	Continued From page 7 (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the required staffing plan was developed as required, potentially affecting the licensee's residents, staff, and any visitors of the licensee. In addition, the facility failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the public. This practice resulted in a level two violation (a violation that did not harm a licensee's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license, was licensed for a capacity of 28 residents, and had a current census of 17 residents. The licensee failed to develop and implement a staffing plan for determining it's staffing level that: - included an evaluation, to be conducted at least	0 470		

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0 470	Continued From page 8 twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. In addition, the facility failed to post a staffing schedule daily in a central location, that was accessible to staff, residents, volunteers, and the public. On June 6, 2022, during the entrance conference at 9:18 a.m. licensed assisted living director (LALD)-A indicated the licensee had not developed a staffing plan. On June 6, 2022, at 10:52 a.m. a white board was noted in the dining room. It was dated May 31, 2022, and identified "kitchen 7A-7P 1 staff", "resident aide 7A-7P - 1 staff, and 7P-7A- 1 staff", and "RN available 24/7/365". The whiteboard failed to be updated daily with the staffing schedule for that day. The licensee's Staffing Requirements -licensed nurse and ULP (unlicensed personnel) policy dated August 1, 2021, identified "A!l staff of [the facility] persons providing assisted living services must be trained and competent in the provision of services consistent with current practice standards appropriate to the resident's needs and promote and be trained to support the assisted living bill of rights." It failed to include the required content.	0 470		

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0 470	Continued From page 9 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 17 residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 480		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 480	Continued From page 10 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated June 6, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to COVID-19, when they did not comply with	0 510		

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	30347	A. BUILDING: _____ B. WING _____	06/10/2022

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0 510	Continued From page 11 MDH guidance for COVID-19 related to wearing appropriate PPE (personal protective equipment). Staff failed to screen for COVID-19 when entering the building for their shift. In addition, staff failed to perform hand hygiene after completing medication administration, blood glucose monitoring, and personal cares. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee failed to ensure employees in direct contact with residents were wearing appropriate personal protective equipment (PPE) as per the Centers for Disease Controls (CDC) and Minnesota Department of Health (MDH) guidelines. On June 6, 2022, at 10:36 a.m. during a tour with licensed assisted living director (LALD)-A, the following was observed: -LALD-A was wearing a face mask, but was not wearing any eye protection; -registered nurse (RN)-B was interacting with residents. She was wearing a face mask but was not wearing eye protection; -housekeeping (HSK)-G was entering and exiting resident apartments wearing a face mask on her chin, failing to cover the mouth and nose, and	0 510		

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0 510	Continued From page 12	0 510		

was not wearing eye protection;
-unlicensed personnel (ULP)-C was wearing a face mask, but was not wearing eye protection;
-kitchen coordinator (KC)-F was wearing a face mask, but was not wearing eye protection; and
-activities director (AD)-H was wearing a face mask, but was not wearing eye protection.

On June 6, 2022, at approximately 10:50 a.m. R1's call light was on and RN-B entered R1's apartment. RN-B was wearing a face mask, but was not wearing eye protection. At 11:03 a.m. she exited the room and stated she had to perform personal cares during his shower. ULP-C was in the room completing the shower. At 11:10 a.m., ULP-C exited the room and was walking in the hallway with her mask below the chin, failing to cover the mouth and nose, and no eye protection. At 11:16 a.m., she was observed administering medication to R2, and at 11:50 she administered medication to R4. She was wearing a face mask, but no eye protection. ULP-C stated that since COVID-19, staff were required to wear a face mask. If there were a positive resident, then they were to wear a gown, mask, eye protection, and gloves when caring for the positive resident. ULP-C entered the building through a staff entrance and then walked to the front entrance to complete her screening.

On June 6, 2022, at 12:00 p.m. KC-F and AD-H were passing out plates of food to the residents. HSK-G was wheeling a resident to the table. KC-F, AD-H, and HSK-G were wearing masks, but failed to wear eye protection.

On June 6, 2022, at 3:59 p.m. RN-B stated when staff arrived for their shift, they were to enter through the front and complete the COVID-19 symptom screen and check their temperature.

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0 510	Continued From page 13 Staff were expected to wear a medical grade face mask at all times. When they had an outbreak, staff were to wear gown, mask, eye protection and gloves. Currently, they did not have any positive cases, so only a "face mask" was required. On June 7, 2022, at 6:15 a.m. R10 was noted in the dining room, alerting staff that surveyor was in the front entrance. ULP-D was observed walking from the kitchen area and through the dining room, passing within two feet of R10, to the front entrance. ULP-D was not wearing a face mask or eye protection. She instructed the surveyor to come in, and began to walk away. The surveyor informed ULP-D of the screening requirement for COVID-19. ULP-D completed the surveyor's screening, and then went to get a key to open a room. She walked past R10 and patted his shoulder. ULP-D returned carrying a key and wearing a face mask, but no eye protection. At 6:30 a.m., ULP-D was noted to be wearing a mask and gloves and carrying eye drops. ULP-D entered R4's room and administered eye drops. ULP-D removed their gloves, but failed to perform hand hygiene. ULP-D set up oral medications and applied gloves. ULP-D entered R8's apartment, administered oral medication and completed blood glucose testing. ULP-D assisted R8 with applying their knee braces and getting dressed. ULP-D removed her gloves and returned to the medication cart without performing hand hygiene. ULP-D was wearing a face mask, but no eye protection. On June 7, 2022, at approximately 7:00 a.m. KC-F was noted in the kitchen setting up for breakfast service. KC-F failed to wear a mask or eye protection.	0 510		

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0 510	Continued From page 14 On June 7, 2022, at 7:10 a.m. LALD-A stated staff should be wearing a medical grade mask at all times. The licensee's 2019-2021 Coronavirus Staff Evaluation Tool identified a coronavirus risk assessment with columns that included date and time, temperature, recent travel, recent exposure, and staff initials. ULP-D's staff schedule indicated she worked on June 4, 2022, 7:00 p.m. until 7:00 a.m., June 5, 2022, 7:00 p.m. until 4:00 a.m., and June 6, 2022, 10:00 p.m. until 7:00 a.m. ULP-D's 2019-2021 Coronavirus Staff Evaluation Tool for June 2022, identified no screenings had been completed. On June 7, 2022, at 7:29 a.m. HSK-G walked through the activity area, hallway and into the kitchen where numerous residents were sitting at the tables. She set her personal beverage container at a table that a resident was sitting at. She then walked down the hallway entering resident rooms letting them know to come to breakfast and assisting them as needed. She walked past R11 in the hall and talked to her about coming to breakfast. She entered R12 and then R3's room to let them know to come to breakfast. She was not wearing a face mask or eye protection. HSK-G's 2019-2021 Coronavirus Staff Evaluation Tool for June 2022, identified COVID screening had been completed. At 7:33 a.m., HSK-G returned to the front entry, placed a face mask and completed the COVID screening for June 7, 2022. On June 7, 2022, at 8:41 a.m. ULP-E administered eye drops to R8. She wore a mask and gloves, but failed to wear eye protection. After administration, she removed the gloves, but	0 510		

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0 510	Continued From page 15 did not complete hand hygiene. On June 7, 2022, at 9:26 a.m. RN-B stated staff were to wear a mask at all times when working. RN-B stated she was not surprised staff were not wearing a mask. She had completed education regarding mask use. RN-B stated she was unaware of the current MDH and CDC guidelines for eye protection. Staff were supposed to be entering the building through the front door and were required to screen at the beginning of their shift. At 12:21 p.m., RN-B stated staff were to wash hands or use hand sanitizer before and after cares, in between medication passes, after soiling, after removing gloves, after oral cares and after pericares. On June 7, 2022, the CDC community transmission level for Pipestone county was high. MDH's COVID-19 PPE and Source Control Grids identified facilities were to wear a face mask and eye protection during high community transmission rates. The licensee's Gloves policy dated August 1, 2021, identified "Gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed." "Procedure: 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out. 6. Dispose used gloves in proper receptacle. 7. Rewash hands."	0 510		

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0 510	Continued From page 16 The Licensee's Hand Washing policy dated August 1, 2021, identified "Proper hand washing techniques should be used to protect the spread of infection. Hand washing shall be completed: - Before, during, and after preparing food - Before eating food - Before and after caring for someone who is sick - Before and after treating a cut or wound - After using the toilet - After changing diapers or cleaning up after someone who has used the toilet - After blowing your nose, coughing, or sneezing - After touching an animal or animal waste - After handling pet food or pet treats - After touching garbage" "Hand Hygiene and Gloves When conducting a procedure requiring the use of gloves, proper hand hygiene should be completed before donning gloves and after removing gloves. Alcohol-Based Hand Sanitizers (ABHS) ABHS should not be used as a replacement for proper hand washing when hands are visibly soiled. However, if hands are not visibly soiled, or soap and water are not available, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used to quickly reduce the number of germs on hands. There is no limit to the number of times you use ABHS before you must use soap and water. A good rule of thumb though, is to wash with soap and water when hands are visibly soiled, after completing cares for someone with c. diff or norovirus, and when the hands have a "filmy" feel to them. " The licensee's Masks policy dated August 1, 2021, identified "Masks are worn to protect the mucous membranes of the eyes, nose and mouth during procedures and tasks that are likely to	0 510		

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0 510	Continued From page 17 generate splashes or sprays of blood, body fluids, secretions or excretions." The licensee's Standard Precautions policy dated August 1, 2021, identified "To ensure standard precautions will be used by all staff when providing housekeeping or maintenance services to residents. The Minnesota Department of Health and/or CDC recommendations will be followed unless other guidelines are set forth." The facility provided a binder labeled infection control/prevention. Noted in the binder COVID-19 Personal Protective Equipment (PPE) Grid for Congregate Care Settings dated June 30, 2021, and COVID-19 Universal Eye Protection Risk Assessment for Long-term Care and Assisted Living-type Settings date June 25, 2021, which was not completed. The binder failed to contain the current recommendations No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for	0 580		

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0 580	Continued From page 18 two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement and maintain a quality management program appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings included: On June 6, 2022, during the entrance conference at 9:18 a.m. licensed assisted living director (LALD)-A stated she had meetings with the registered nurse regarding falls; however, the meetings did not meet the requirements. The licensee's Quality Management Project policy dated August 1, 2021, identified "[the licensee] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years. The MN Assisted Living requirement for "Quality Management" is: The facility shall engage in quality management	0 580		

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0 580	Continued From page 19 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580		
0 650 SS=F	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs;	0 650		

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0 650	Continued From page 20 (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel (ULP)-C and ULP-D, and registered nurse (RN)-B reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C's personnel file identified she was hired on March 23, 2021. ULP-C's employee record lacked evidence of a performance review since date of hire.	0 650		

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0 650	Continued From page 21 ULP-D ULP-D's personnel file identified she was hired on June 11, 2018. ULP-D's employee record identified she had performance evaluations on December 11, 2018, December 20, 2019, and December 16, 2020. There was no evidence a performance evaluation had been completed in the last year. RN-B RN-B's personnel file identified she was hired on December 24, 2019. RN-B's employee record identified she had a performance evaluation on December 23, 2020. There was no evidence a performance evaluation had been completed in the last year. On June 10, 2022, at approximately 9:00 a.m. licensed assisted living director (LALD)-A stated she was in charge of annual performance evaluations for the nurse, housekeeping, and kitchen staff. RN-B was responsible for completing on them on the ULP staff. On June 10, 2022, at 10:44 a.m. RN-B stated she gave completed annual performance evaluations to LALD-A. If they were not in the employee files then they had not been completed. The licensee's Employee Records policy dated August 1, 2021, identified employee records for each person will include documentation of annual performance reviews that identify areas of improvement needed and training needs. No further information was provided. TIME PERIOD FOR CORRECTION:	0 650		

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0 650	Continued From page 22 Twenty-One (21) days	0 650		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included documentation of a completed health history and symptom screening, including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of three employees (registered nurse (RN)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 660		

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0 660	Continued From page 23	0 660		

resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).

The findings include:

The licensee's TB facility risk assessment dated June 4, 2021, indicated they were a low risk.

RN-B's personnel file identified she was hired on December 24, 2019. RN-B's personnel file had a TB quantiferon (TB blood test) dated January 19, 2017, that was negative. The personnel file had no evidence a TB symptom screening or any testing was completed upon hire, or within 90 days prior to the hire date.

On June 10, 2022, at 1:34 p.m. RN-B stated she was unaware she was required to have a symptom screening or TB testing upon hire because she had the TB quantiferon in the past.

The licensee's Tuberculosis Screening policy dated August 1, 2021. identified "[The licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR)."
"Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial

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0 660	Continued From page 24 (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented. 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 680	Continued From page 25	0 680		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and have available a written emergency disaster plan with all required content outlined in Appendix Z. This had the potential to affect all current residents, staff, and visitors.	0 680		

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0 680	Continued From page 26 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Disaster Planning and Emergency Preparedness binder, undated, included general policies for various threats and a hazard risk assessment, which included threats such as fire, severe weather, flooding, bomb threat. The binder lacked an assessment of the at risk population's needs. The facility's plan lacked the following required content: -an assessment of the at risk population's needs; - a comprehensive program to include infectious diseases; - a description of the population served by the licensee; - process for emergency preparedness (EP) collaboration with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situations; - development of policies/procedures to address: - evacuation plan; - shelter in place; - the medical record documentation system to preserve resident information; - use of volunteers; - emergency staff strategies; and	0 680		

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0 680	Continued From page 27 - the facility's role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for resident physicians; - contact information for federal, state, tribal, local EP staff, or the ombudsman; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On June 10, 2022, at 3:02 p.m. licensed assisted living director (LALD)-A stated she had been working on the emergency preparedness plan and knew it was not completed. The facility used its old policies, prior to August 1, 2021, and utilized other resources to complete the plan. LALD-A confirmed the plan lacked the above content. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 700	Continued From page 28	0 700		
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records were protected against unauthorized disclosure of both electronic and written records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 6, 2022, at 11:16 a.m. unlicensed personnel (ULP)-C set up medication for R2, locked the medication cart and went down the hallway to R2's apartment. ULP-C failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving, and it was visible to other residents, staff, and visitors.	0 700		

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0 700	Continued From page 29 On June 7, 2022, at 6:30 a.m. the surveyor observed a laptop screen to be unlocked with resident information visible. ULP-D prepared medication for R2, locked the medication cart and went down the hallway to R8's apartment. ULP-D failed to lock the laptop screen prior to walking away, and it was visible to other residents, staff, and visitors. On June 7, 2022, at 9:12 a.m. ULP-E prepared medication for R2, locked the medication cart and went down the hallway to R2's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving. Housekeeping and kitchen staff were in the area of the medication cart upon ULP-E's return. At 9:13 a.m., ULP-E prepared medications for R6, locked the medication cart and went down the hallway to R6's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including resident name and medications she was receiving. At approximately 9:15 a.m., ULP-E prepared medications for R8, locked the medication cart and went down the hallway to R8's apartment. ULP-E failed to lock the laptop screen prior to walking away. The laptop screen contained information including the names of all the residents. With each occurrence, the computer screen was visible to other residents, staff and visitors. On June 7, 2022, at 9:26 a.m. registered nurse (RN)-B stated staff were to lock the laptop screen when walking away from the medication cart so that is not visible to other staff, residents, and visitors. The licensee's policy Resident record -	0 700		

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0 700	Continued From page 30 information and content policy dated August 1, 2021, identified "Resident records whether written or electronic will be protected against loss, tampering, or unauthorized disclosure." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 31 by: Based on observation and interview, the licensee failed provide smoke alarms in all sleeping rooms throughout the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on June 07, 2022, at approximately 10:40 a.m. with Maintenance (M)-I, it was observed that smoke alarms were not installed in sleeping rooms #13 and #25 as required by statute. An interview with M-I verified this deficient finding at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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residents; and
(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.
(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.
(d) Fire safety and evacuation plans shall be readily available at all times within the facility.
(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year.
(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.

This MN Requirement is not met as evidenced by:
Based on a record review and interview, the licensee failed to develop a fire safety and evacuation plan with required elements. This had the potential to affect all staff, residents, and visitors.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic

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0 810	Continued From page 33 failure that has affected or has potential to affect a large portion or all of the residents). Findings include: A record review and interview were conducted on May 17, 2022, at approximately 9:50 a.m. with Licensed Assisted Living Director (LALD)-A and Maintenance (M)-I on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. Record review of the available documentation indicated that the licensee did not have employee actions to be taken in the event of a fire or similar emergency. During interview, LALD-A indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan. During interview, LALD-A indicated that the fire safety and evacuation plan for the facility lacked these provisions. Record review of the available documentation indicated that the fire safety and evacuation plan did not include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. During interview, LALD-A indicated that the fire safety and evacuation plan for the facility lacked these provisions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and	01370		

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01370	Continued From page 35 (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-C and ULP-D) completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021. On June 6, 2022, at approximately 11:10 a.m. ULP-C exited R1's apartment after assisting him to shower. On June 6, 2022, at 11:13 a.m. ULP-C stated she was trained by another ULP on how to administer medications. The nurse did not train or competency test her on medication administration or other delegated tasks. On June 6, 2022, at 11:16 a.m. ULP-C was	01370		

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observed administering medication to R2, and at 11:50 a.m. she administered medication to R4.

ULP-C's employee record lacked evidence competency testing was completed on the following required topics:
-appropriate and safe techniques in personal hygiene and grooming, including:
-hair care and bathing;
-care of teeth, gums, and oral prosthetic devices;
-care and use of hearing aids; and
-dressing and assisting with toileting; and
-standby assistance techniques and how to perform them.

ULP-D
ULP-D was hired on June 11, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021.

On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4.

On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed.

ULP-D's employee record lacked evidence training was completed on the following required topics:
-documentation requirements for all services provided;
-maintenance of a clean and safe environment;
-training on the prevention of falls;
-standby assistance techniques and how to

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perform them;
-medication, exercise, and treatment reminders;
-communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;
-awareness of confidentiality and privacy;
-understanding appropriate boundaries between staff and residents and the resident's family;
-procedures to use in handling various emergency situations;

In addition, ULP-D's employee record lacked evidence competency testing was completed on the following required topics:
-standby assistance techniques and how to perform them.

On June 6, 2022, at 3:52 p.m. RN-B stated she was working on forms for competency testing, but she had not implemented that yet. New staff completed the online training and tested on that. Then, they followed other ULP for a couple days, and then they were able to pass medications with other ULP observing them. New staff were then allowed to pass medications and perform other delegated tasks independently. RN-B was available to answer questions and occasionally would observe staff. She confirmed there was no formal training or competency testing completed by the RN.

The licensee's Competency Training Evaluations policy, dated August 1, 2021, identified "When a registered nurse or licensed health professional staff of [the facility] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability

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FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

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01370	Continued From page 38	01370		

to competently follow the procedures and perform the tasks."
"1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel.
2. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks.
3. The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies.
4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN.
5. Training and competency evaluations for all ULP's will include:
a) Documentation requirements for all services provided
b) Reports of changes in the resident's condition to the supervisor designated by the facility
c) Basic infection control, including blood-borne pathogens
d) Maintenance of a clean and safe environment
e) Appropriate and safe techniques in personal hygiene and grooming, including:
i. hair care and bathing
ii. care of teeth, gums, and oral prosthetic devices
iii. care and use of hearing aids
iv. dressing and assisting with toileting
f) Training on the prevention of falls
g) Standby assistance techniques and how to perform them

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01370	Continued From page 39 h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=F	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident;	01380		

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01380	Continued From page 40 (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two unlicensed personnel (ULP)-C and ULP-D completed training and competency evaluations in all required training topics. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021. On June 6, 2022, at approximately 11:10 a.m. ULP-C exited R1's apartment after assisting him to shower. On June 6, 2022, at 11:13 a.m. ULP-C stated she was trained by another ULP on how to administer medications. The nurse did not train or	01380		

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01380	Continued From page 41 competency test her on medication administration or other delegated tasks. On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R2, and at 11:50 a.m. she administered medication to R4. ULP-C's employee record lacked evidence competency testing was completed on the following required topics: -appropriate and safe techniques in personal hygiene and grooming, including: -reading and recording temperature, pulse, and respirations of the resident; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications or treatments as required; -blood glucose monitoring; and -insulin administration. ULP-D ULP-D was hired on June 11, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021. On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4. On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed.	01380		

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01380	Continued From page 42 ULP-D's employee record lacked evidence training was completed on the following required topics: -observing, reporting, and documenting resident status; -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -blood glucose monitoring; and -applying braces. In addition, ULP-D's employee record lacked evidence competency testing was completed on the following required topics: -reading and recording temperature, pulse, and respirations of the resident; -blood glucose monitoring; and -applying braces. On June 6, 2022, at 3:52 p.m. RN-B stated she was working on forms for competency testing, but she had not implemented that yet. New staff completed the online training and tested on that. Then they followed other ULP for a couple days. They were then allowed to pass medications with another ULP observing them. Staff were then allowed to pass medications and perform other delegated tasks independently. RN-B was available to answer questions and occasionally would observe staff. She confirmed there was no formal training or competency testing completed by the RN. The licensee's Competency Training Evaluations policy, dated August 1, 2021, identified "When a registered nurse or licensed health professional	01380		

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01380	Continued From page 43	01380		

staff of [the facility] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks."
"1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel.
2. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks.
3. The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies.
4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN.
"training and competency evaluation for unlicensed personnel providing assisted living services must include:
a. Observing, reporting, and documenting resident status
b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel
c. Reading and recording temperature, pulse, and respirations of the resident
d. Recognizing physical, emotional, cognitive, and developmental needs of the resident
e. Safe transfer techniques and ambulation
f. Range of motioning and positioning
g. Administering medications or treatments

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01380	Continued From page 44 as required" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted direct	01440		

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01440	Continued From page 45 supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two unlicensed personnel (ULP)-F with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021. On June 6, 2022, at approximately 11:10 a.m. ULP-C exited R1's apartment after assisting him to shower. On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R2, and at 11:50 a.m. she administered medication to R4. On June 8, 2022, at 6:41 a.m. ULP-C was observed supervising blood glucose monitoring and insulin administration for R5. ULP-C's employee file lacked evidence a 30 day supervision had been performed by a RN.	01440		

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01440	Continued From page 46 ULP-D ULP-D was hired on June 11, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021. On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4. On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed. ULP-D's employee file lacked evidence a 30 day supervision had been performed by a RN. On June 10, 2022, at 10:51 a.m. RN-B stated she had not been completing 30 day supervisory visits. She was unaware of the requirement. The licensee's Supervision of Staff - Delegated Services policy dated August 1, 2021, identified "direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for Falls Landing Assisted Living and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01470	Continued From page 47	01470		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any	01470		

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01470	Continued From page 48 training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living facility statutes included all the required content for three of three employees (unlicensed personnel (ULP)-C, ULP-D, and registered nurse (RN)-B) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C. ULP-D, and RN-B's employee files lacked	01470		

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evidence their orientation contained the following topics as required, prior to providing assisted living services on August 1, 2021 :
- an overview of Assisted Living statutes 144G;
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person;
- the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;
- the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person.

ULP-C
ULP-C was hired on March 23, 2021, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the assisted living license beginning August 1, 2021.

On June 6, 2022, at approximately 11:10 a.m. ULP-C exited R1's apartment after assisting him to shower.

On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R7, and at 11:50 a.m. she administered medication to R4.

On June 8, 2022, at 6:41 a.m. ULP-C was observed supervising blood glucose monitoring and insulin administration for R5.

ULP-C's record identified she had completed the following training:
-Guide to Assisted Living - MN on April 6, 2022, which included an overview of Assisted Living statutes 144G and an introduction and review of the facility's policies and procedures related to the

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provision of assisted living services by the individual staff person;
-Assisted Living Bill of Rights on March 29, 2022; and
-Person Centered Care Principles on May 4, 2022.
Although there was evidence training was completed, it was not completed prior to providing assisted living services on August 1, 2021.

ULP-D
ULP-D was hired on June 11, 2018, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the assisted living license beginning August 1, 2021.

On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4.

On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed.

ULP-D's record identified she had completed the following training:
-Assisted Living Bill of Rights on December 13, 2021; and
-Person Centered Care Principles on December 31, 2021.

ULP-D's record lacked evidence she had completed the following:
- an overview of Assisted Living statutes 144G; and
- an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff

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01470	Continued From page 51 person. RN-B RN-B was hired on December 24, 2019, to provide direct care and services under the comprehensive home care licence. She began providing direct care and services under the assisted living license beginning August 1, 2021. RN-B's record identified she had completed the following training: -Assisted Living Bill of Rights on November 11, 2021 RN-B's record lacked evidence she had completed the following: - an overview of Assisted Living statutes 144G; and - an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person. - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On June 10, 2022, at 12:45 p.m. licensed assisted living director (LALD)-A confirmed the online training records was the only training completed since assisted living licensure on August 1, 2021. She was unaware it needed to be completed prior to August 1, 2021, and she had assigned it on the online training system to be completed with staff's annual training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01530	Continued From page 52	01530		
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure three of three employees (unlicensed personnel (ULP)-C, ULP-D and registered nurse (RN)-B) received the required amount of dementia care training, in the required time frame in accordance with 144G.64 with records reviewed.	01530		

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01530	Continued From page 53 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The licensee provided services under an assisted living license. During the entrance conference on June 6, 2022, at approximately 9:18 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B stated the licensee had residents with the diagnosis of dementia, but had no special care unit or program. ULP-C ULP-C began providing services under the comprehensive home care license on March 23, 2021, and began providing services under the assisted living licensure on August 1, 2021. ULP-C's employee record contained evidence ULP-C had received five hours dementia related training on March 16, 2021, and 2.5 hours of training in May 2022. ULP-C lacked the required eight hours of initial training. On On June 6, 2022, at approximately 10:50 a.m. through 11:50 a.m. ULP-C was observed completing cares and administering medications to several residents.	01530		

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01530	Continued From page 54 ULP-D ULP-D began providing services under the comprehensive home care license on June 11, 2018, and began providing services under the assisted living licensure on August 1, 2021. ULP-D's employee record contained evidence ULP-D had received three hours dementia related training on December 23, 2020, and 2.25 hours of training On December 14, 2021. ULP-D lacked the required eight hours of initial training. On June 7, 2022, approximately 6:15 a.m. through 6:45 a.m. ULP-D was observed administering medication, placing knee braces and assisting a resident to get dressed. RN-B RN-B began providing services under the comprehensive home care license on December 24, 2019, and began providing services under the assisted living licensure on August 1, 2021. RN-B's employee record contained evidence RN-B had received 3.25 hours dementia related training in January 2021, and 3.25 hours of training in November 2021. RN-B lacked the required eight hours of initial training. On June 10, 2022, at approximately 12:45 p.m. licensed assisted living director (LALD)-A confirmed the dementia training was completed on line. LAND-A confirmed the employees did not have the required amount of training in dementia care. LALD-A stated with the new licensure additional training was included in the employees annual training. No further information was provided.	01530		

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01530	Continued From page 55 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure ongoing comprehensive assessments were completed timely for six of six residents (R5, R4, R6, R7, R8 and R2), and failed to complete a change in condition assessment was for one of one resident (R2) with record	01620		

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01620	Continued From page 56 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R5 R5 was admitted on January 15, 2022. R5's service plan dated January 15, 2022, was signed by the resident representative and the facility staff. The service plan contained check boxes to identify a description of the services received, the identification of staff who will provide the services, and the schedule and methods of monitoring assessments; however, none of the boxes were marked. R5's June 2022, medication administration record identified she received medication administration by the facility staff three times a day, including the administration of Victoza (diabetes) injectable medication. R5's RN Baseline Assessment was dated January 15, 2022. R5's 14 Day Assessment was dated January 31, 2022 (16 days after admission). On June 9, 2022, at 2:53 p.m. registered nurse (RN)-B confirmed the assessment had not been completed within 14 days.	01620		

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R4
R4's service plan dated September 13, 2020, identified he received bathing, applying TED (thrombo embolic deterrent) stockings, dressing, and medication management.

R4's last 90 Day Assessment was dated January 25, 2022. There had been no further assessments completed after January 25, 2022.

On June 9th, 2022, at 12:20 p.m. RN-B confirmed there had been no assessments completed after January 25, 2022.

R6
R6's service plan dated December 3, 2021, identified she received assistance with with bathing, applying TED stockings, blood glucose monitoring, and medication management.

R6's last 90 day assessment was completed March 1, 2022. There were no further assessments completed after March 1, 2022.

On June 9th, 2022, at 12:22 p.m. RN-B confirmed no further assessments had been completed after March 1, 2022.

R7
R7's service plan dated July 30, 2021, identified she received assistance with bathing, applying TED stockings, and medication management.

R7's previous two 90 Day Assessments were dated December 8, 2021, and March 8, 2022. There were no further assessments completed after March 8, 2022.

On June 9, 2022, at 12:18 p.m. RN-B confirmed no further assessments had been completed

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01620	Continued From page 58 after March 8, 2022. R8 R8's service plan dated August 27, 2021, identified he received assistance with bathing, blood glucose monitoring, and medication management. R8's last 90 Day Assessments were dated December 2, 2022, and March 1, 2022. There were no further assessments completed after March 1, 2022. On June 9, 2022, at 4:00 p.m. RN-B confirmed no further assessments had been completed after March 1, 2022. R2 R2's service plan dated August 2, 2021, identified she received assistance with with bathing, dressing, applying TED hose, and medication management. R2's last 90 Day Assessment was dated March 8, 2022. On June 6, 2022, at 11:16 a.m. during a medication administration observation, R2 was noted to have purple green discoloration to the entire left side of her face with some swelling noted under the left eye. ULP-C identified she had a fall in the past. R2 stated that she was trying to get to her walker and fell. In addition, R2's fall report, completed by unlicensed personnel (ULP)-D, identified she had a fall on May 13, 2022, at 10:10 p.m. Description of the fall indicated "Staff was doing bed check routines and had saw her sitting on the floor and was trying to get up. Staff also saw her big bruise	01620		

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socket underneath of her left eye." Injury information included "Large hematoma sustained to lower left cheek bone, approx 6 cm across 4 cm height. with some protrusion, laceration. Does have small hematoma visible above eye."

On June 9, 2022, at 9:52 a.m. RN-B confirmed there have been no further assessments completed after March 8, 2022. R2 was due for her annual review last month but it had not yet been completed.

On June 9, 2022, at 10:35 a.m. RN-B stated no formal assessments were completed after a fall. A fall with injury would be a change in condition and a comprehensive assessment would be indicated. The process after a fall included a "huddle," but no formal assessment process.

The licensee's Assessments, Reviews, and Monitoring policy dated August 1, 2021, identified the following:
"1. The initial nursing assessment or reassessment must include all the elements of the uniform assessment tool as required, conducted in person (unless see #2), be in writing, dated, and signed by the registered nurse who conducted the assessment.
2. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.
3. Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted

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01620	Continued From page 60 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." "6. The facility will conduct a nursing assessment during a holiday, and the weekend for a resident who is ready to be discharged from the hospital and return to the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 61 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for two of three residents (R4, R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R4 and R5 began receiving services under the assisted living licensure on August 1, 2021. R4 R4's service plan dated September 13, 2020, identified he received bathing, applying TED (thrombo embolic deterrent) stockings, dressing, and medication management. R4's service plan incorrectly indicated the schedule and methods of monitoring assessments of the resident to include the initial assessment would be completed within five days after initiation of home care services. It failed to	01650		

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01650	Continued From page 62 identify supervision of staff performing delegated tasks would be completed within 30 days. R5 R5's service plan dated January 15, 2022, was signed by the resident representative and the facility staff. The service plan contained check boxes to identify a description of the services received, the identification of staff who will provide the services, and schedule and methods of monitoring assessments; however, none of the boxes were marked. R5's June 2022, medication administration record identified she received medication administration by the facility staff three times a day, this included administration of Victoza (diabetes) injectable medication. R5's 90 Day Assessment dated March 31, 2022, identified she received bathing, medication management, and blood glucose testing. On June 9, 2022, at 2:53 p.m. registered nurse (RN)-B stated R4's service plan was on the old form and she was unaware it lacked the correct information. R5's service plan was the current form, but she did not realize that none of the boxes were marked. The licensee's Service Plan policy dated August 1, 2021, identified "A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff	01650		

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01650	Continued From page 63 who will be providing services (RN LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring. f. A schedule and method for the next planned monitoring of staff providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	01700		

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diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the licensee failed to have a medication assessment for three of three residents (R2, R5, and R7) that included interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications to prevent diversion of medications.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R2's "Medication/Treatment/Therapy Management Plan" dated April 19, 2021, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

R5's "Medication/Treatment/Therapy Management Plan" dated January 15, 2022, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications.

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01700	Continued From page 65 R7's "Medication/Treatment/Therapy Management Plan" dated September 9, 2021, failed to identify risk for diversion of medications and interventions to manage the residents's medication to prevent diversion of medications. On June 9, 2022, at 11:00 a.m. registered nurse (RN)-B stated the assessment did not include the required information regarding drug diversion. She was unaware the assessment they used did not meet the requirement." The licensee's Medication Management -Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified the assessment was to include "The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a	01710		

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01710	Continued From page 66 minimum, annually. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed annual medication re-assessments for one of two residents (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's record lacked documentation of an annual medication re-assessment. The most recent medication assessment was dated April 19, 2021. On June 9, 2022, at 9:52 a.m. RN-B confirmed she had not completed the annual medication re-assessment that was due for R2 in April 2022. The licensee's Medication Management-Assessment, Monitoring & Reassessment policy dated August 1, 2021, identified "[the facility] will monitor and reassess the resident's medication management services as needed when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually." No further information was provided.	01710		

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01710	Continued From page 67 TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use	01730		

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to prevent possible complications or adverse reactions.
(b) The medication management record must be current and updated when there are any changes.
(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for three of three residents (R2, R5, and R6) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R2
R2 began receiving services on January 16, 2016, under the comprehensive home care license with diagnoses that included, but were not limited to, vascular dementia, chronic obstructive pulmonary disease, and osteoarthritis.

R2's service plan dated August 2, 2021, identified

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she received assistance with medication management.

R2's Medication/Treatment/Therapy Management Plan dated April 19, 2021, failed to include the following required content:
- identification of medication management tasks that may be delegated to unlicensed personnel.

On June 6, 2022, at 11:16 a.m. unlicensed personnel (ULP)-C administered Incruse Elipta (inhaler to treat chronic obstructive pulmonary disease) to R2.

On June 9, 2022, at 9:52 a.m. registered nurse (RN)-B verified R2's Medication/Treatment/Therapy Management Plan did not contain the identification of medication management tasks that may be delegated to unlicensed personnel.

R5
R5 began receiving services on January 15, 2022, with diagnoses that included, but were not limited to, diabetes and osteoarthritis.

R5's service plan dated January 15, 2022, did not indicate R5 received medication administration.

On June 8, 2022, at 6:41 a.m. ULP-E was observed supervising blood glucose monitoring and insulin administration for R5.

R5's June 2022, medication administration record identified she received medication administration by the facility staff three times a day, this included administration of Victoza (diabetes) injectable medication.

R5's Medication/Treatment/Therapy Management

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01730	Continued From page 70 Plan dated January 15, 2022, failed to include the following required content: - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff to notify an RN when problems arose; and - any resident/client-specific requirements (e.g., parameters: blood sugar, blood pressure, pulse, etc.) R6 R6 began receiving services on December 1, 2021, with diagnoses that included Alzheimer's disease, diabetes and chronic obstructive pulmonary disease. R6's service plan dated December 3, 2021, identified R6 received assistance with medication administration. R6's 90 Day Assessment dated March 31, 2022, identified she received medication management. R6's Medication/Treatment/Therapy Management Plan dated December 1, 2021, failed to include the following required content - identification of medication management tasks that may be delegated to unlicensed personnel. On June 9, 2022, at 9:52 a.m. RN-B verified R2, R5, and R6's Medication/Treatment/Therapy Management Plan did not contain the identification of medication management tasks that may be delegated to unlicensed personnel. The licensee's Medication Management Individualized Plan policy dated August 1, 2022, identified the facility "will develop and maintain a current individualized medication management record for each resident based on the resident's	01730		

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01730	Continued From page 71 assessment that must contain the following:" "e. Identification of medication management tasks that may be delegated to unlicensed personnel". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01750 SS=I	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) completed training and competency evaluations in all required training topics. This resulted in an immediate order issued on July 15, 2022, at approximately 1:40 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	01750		

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or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).

The findings include:

ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021.

On June 6, 2022, at 11:13 a.m. ULP-C stated she was trained by another ULP on how to administer medications. The nurse did not train or competency test her on medication administration or other delegated tasks.

On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R7, and at 11:50 a.m. she administered medication to R4.

ULP-C's employee record lacked evidence competency testing was completed on administering medications or treatments as required.

On June 6, 2022, at 3:52 p.m. RN-B stated she was working on forms for competency testing, but she had not implemented that yet. New staff completed the online training and tested on that. They then followed other ULP for a couple days. They were then allowed to pass medications with the training and ULP observing them. Staff were then allowed to pass medications and perform other delegated tasks independently. RN-B was

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available to answer questions and occasionally would observe staff. RN-B confirmed there was no formal training or competency testing completed by the RN.

The licensee's Competency Training Evaluations policy dated August 1, 2021, identified "When a registered nurse or licensed health professional staff of [the facility] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks."
"1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel.
2. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks.
3. The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies.
4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN.
"training and competency evaluation for unlicensed personnel providing assisted living services must include:"
"g. Administering medications or treatments as required"

No further information was provided.

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01750	Continued From page 74 TIME PERIOD FOR CORRECTION: Immediate On July 18, 2022, the immediacy of correction order 1750 was removed; however, non-compliance remains at level 3, Widespread (I). TIME PERIOD FOR CORRECTION: Two (2) days	01750		
01830 SS=F	144G.71 Subd. 14 Renewal of prescriptions Prescriptions must be renewed at least every 12 months or more frequently as indicated by the assessment in subdivision 2. Prescriptions for controlled substances must comply with chapter 152. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to renew prescriptions at least every 12 months for three of three residents (R2, R4, and R7) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's last signed physician orders were dated February 17, 2021. R2's record lacked an annual	01830		

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01830	Continued From page 75 renewal of physician orders for medications. R2 began receiving services on January 16, 2016, under the comprehensive home care license, and August 1, 2022, under the assisted living license. R2 had diagnoses that included vascular dementia, chronic obstructive pulmonary disease (COPD), and osteoarthritis. R2's service plan dated August 2, 2021, identified she received assistance with medication management. R2's Medication/Treatment/Therapy Management Plan dated April 19, 2021, identified she received medication administration. On June 6, 2022, at 11:16 a.m. unlicensed personnel (ULP)-C administered Incruse Elipta (inhaler to treat chronic obstructive pulmonary disease) to R2. On June 7, 2022, at approximately 9:12 a.m. ULP-E was observed administering medications to R2. R2's medication administration record dated June 1, 2022, through June 7, 2022, identified the following medications had been administered: -Brovana (inhaled medication for COPD) -Incruse Elipta (inhaled medication for COPD) -budesonide (nebulizer medication for COPD) -aspirin (heart health) -citalopram (depression) -montelukast (allergies) -Vitamin D-3 (supplement) -simvastatin (cholesterol) -levothyroxine (thyroid hormone)	01830		

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01830	Continued From page 76 -nystatin (for oral yeast infection) -omeprazole (gastric reflux) -donepazil (dementia) -furosemide (fluid retention) R2's record contained signed prescriber orders for the medications listed above dated February 17, 2021. There were no other more recent prescriber orders. R4 R4's last signed physician orders were dated February 17, 2021. R2's record lacked an annual renewal of prescriber orders for medications. R4 began receiving services on September 13, 2020, under the comprehensive home care license and August 1, 2022, under the assisted living license. R4's diagnoses that included depression, anxiety, hypertension and venous insufficiency. R4's service plan dated September 24, 2020, identified he received assistance with medication management. R4's Medication/Treatment/Therapy Management Plan dated September 14, 2021, identified he received medication administration. On June 6, 2022, at 11:50 a.m. ULP-C administered oral medication to R4. On June 7, 2022, at 6:30 a.m. ULP-D was observed administering eye drops to R4. R4's medication administration record dated June 1, 2022, through June 7, 2022, identified the following medications had been administered:	01830		

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-levothyroxine (thyroid hormone replacement)
-aspirin (heart health)
-multivitamin (supplement)
-calcium (supplement)
-acetaminophen (pain)
-polyethylene glychol (constipation)
-myrbetriq (increased urinary frequency)
-alendronate (osteoporosis)
-furosemide (fluid retention)
-lisinopril (heart)
-artificial tears (lubricating eye drops)

R4's record contained signed prescriber orders for the medications listed above dated February 17, 2021. There were no other more recent prescriber orders.

R7
R7's last signed physician orders were dated February 17, 2021. R7's record lacked an annual renewal of physician orders for medications.

R7 began receiving services on September 8, 2020, under the comprehensive home care license and August 1, 2022, under the assisted living license.

R7's diagnoses that included history of cerebrovascular accident (stroke), chronic kidney disease, chronic obstructive pulmonary disorder, atrial fibrillation, and diabetes.

R7's service plan dated July 30, 2021, identified she received assistance with medication management.

R7's Medication/Treatment/Therapy Management Plan dated September 14, 2021, identified she received medication administration.

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01830	Continued From page 78 R7's medication administration record, dated June 1, 2022, through June 7, 2022, identified the following medications had been administered: -diltiazem (heart) -hydrochlorothiazide (fluid retention) -multivitamin (supplement) -Eliquis (atrial fibrillation) -atorvastatin (cholesterol) -vitamin B12 (supplement) -melatonin (sleep) -calcium (supplement) -potassium (supplement) R7's record contained signed prescriber orders for the medications listed above dated February 17, 2021. There were no other more recent prescriber orders. On June 9, 2022, at 10:05 a.m. registered nurse (RN)-B confirmed the annual orders for all residents had not been completed in the last year, and she was working on getting them completed. The licensee's Medication & Treatment Orders -Renewal policy dated August 1, 2021, identified "Residents who receive medication management services by [the facility] will have a current physician prescribed medication or treatment/therapy orders on record. Medication and treatment orders must be renewed at least every 12 months or more frequently as required." "Medication and treatment/therapy orders will be sent to the resident's authorized prescriber for signatures at least every 12 months or more frequently if medications or services are new or changed." No further information was provided.	01830		

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01830	Continued From page 79 TIME PERIOD FOR CORRECTION: Seven (7) days	01830		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure time sensitive medications were dated when opened and had a pharmacy label for two of two residents (R2 and R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On June 6, 2022, at 11:16 a.m. unlicensed personnel (ULP)-C administered Incruse Elipta (inhaler to treat chronic obstructive pulmonary disease) to R2. There was no open date marked on the inhaler or the box it was stored in.	01890		

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01890	Continued From page 80 On June 6, 2022, at 11:21 a.m. a check of the medication cart was completed with ULP-C. It was noted R3 had an open bottle of brimonidine dated as opened on May 8, 2022 (had been opened 29 days). ULP-C stated it had been administered that morning and they use eye drops until they were gone. On June 6, 2022, at 3:31 p.m. registered nurse (RN)-B stated medications should be removed from use and not be administered after the manufacturer's recommended use date. Incruse Ellipta manufacturer directions dated June 2019, identified : Safely throw away INCRUSE ELLIPTA in the trash 6 weeks after you open the tray or when the counter reads "0", whichever comes first. Write the date you open the tray on the label on the inhaler." Brimonidine manufacturer directions dated October 2020, identify "Discard after 28 days of opening." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal.	01910		

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	30347	A. BUILDING: _____ B. WING _____	06/10/2022

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01910	Continued From page 81 (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed upon disposition, document in the resident's record the disposition of the medication including the medication's prescription number as applicable for one of one discharged resident (R9) with record review. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R9's discharge summary dated December 30, 2021, identified R9 was discharged to a higher level of care. R9's Disposal Records identified on January 10, 2022, traimcinolone (steroid ointment),	01910		

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01910	Continued From page 82 preservision (vitamin), grape seed (supplement), Vitamin B12 (supplement), furosemide (diuretic), omeprazole (stomach reflux), allopurinol (gout), aspirin (heart health), amlodipine (heart), carvedilol (heart), Vitamin D3 (vitamin), and warfarin (blood thinner) were destroyed by bringing to the sheriff's department drop box. They failed to identify the prescription number for any of the identified medications. On June 10, 2022, at 2:45 p.m. registered nurse (RN)-B stated she was unaware that she was required to record the prescription number and had not been placing that in the form. The licensee's Medication Disposal policy dated August 1, 2021, identified "Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940		

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01940	Continued From page 83 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management record to include all required content for five of five residents (R2, R4, R5, R6, and R8) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	01940		

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01940	Continued From page 84 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services on January 16, 2016, under the comprehensive home care license with diagnoses including vascular dementia, chronic obstructive pulmonary disease, and osteoarthritis. R2 began receiving services under the assisted living licensure starting on August 1, 2021. R2's service plan dated August 2, 2021, identified she received TED (thrombo embolic deterrent) hose (compression stockings to increase vascularity and reduce swelling) assistance. R2's medical record lacked a physician's order for TED hose. R2's Medication/Treatment/Therapy Management Plan dated April 19, 2021, failed to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to	01940		

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01940	Continued From page 85 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On June 9, 2022, at 9:52 a.m. registered nurse (RN)-B verified R2's Medication/Treatment/Therapy Management Plan did not contain the required information for TED hose services. R4 R4 began receiving services on September 13, 2020, under the comprehensive license and began receiving services under the assisted living licensure starting on August 1, 2021. R4 had diagnoses including venous insufficiency, osteoporosis, hypothyroidism and depression. R4's service plan dated September 4, 2020, identified he received TED hose assistance. R4's Task Administration record dated June 1, 2022, through June 7, 2022, identified he received Tubi-Grip stocking assistance to put on Tubi-Grip socks in the morning. R4's task administration record did not include TED hose assistance. R4's physician's orders signed on February 17, 2021, identified an order for Tubi-Grip stockings to be placed on in the morning and off at night. R4's "Medication/Treatment/Therapy Management Plan" dated September 14, 2021, failed to include the following:	01940		

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01940	Continued From page 86 (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On June 9, 2022, at 12:20 p.m. RN-B verified R4's Medication/Treatment/Therapy Management Plan did not contain the required information for Tubi-Grip socks. R5 R5 began receiving services on January 15, 2022, with diagnoses including diabetes and osteoarthritis. R5's service plan dated January 15, 2022, failed to identify the service of blood glucose monitoring. R5's physician orders identified an order dated March 2, 2022, for blood glucose monitoring daily and as needed. R5's "Medication/Treatment/Therapy	01940		

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01940	Continued From page 87 Management Plan" dated January 15, 2022, failed to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. R5's 90 Day Assessment dated March 31, 2022, identified she received blood glucose testing. On June 8, 2022, at 6:41 a.m. ULP-E was observed supervising blood glucose monitoring and insulin administration for R5. On June 9, 2022, at 9:52 a.m. registered nurse RN-B verified R5's Medication/Treatment/Therapy Management Plan did not contain the required information for blood glucose monitoring. R6 R6 began receiving services on December 1, 2021, with diagnoses including Alzheimer's disease, diabetes, bilateral lower extremity edema, and chronic obstructive pulmonary	01940		

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01940	Continued From page 88 disease. R6's service plan dated December 3, 2021, identified R6 received assistance with blood glucose monitoring and TED hose administration. R6's 90 Day Assessment dated March 31, 2022, identified she received blood glucose testing. R6's medical record included a Continuity of Care Document (Ambulatory Clinical Summary) dated November 29, 2021, identified by RN-B to be physician's orders. The document lacked a physician signature or electronic signature on the document. It included an order for blood glucose monitoring once daily and an order for compression stockings use as directed. R6's Medication/Treatment/Therapy Management Plan dated December 1, 2021, failed to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any	01940		

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01940	Continued From page 89 changes. On June 9, 2022, at 9:52 a.m. RN-B verified R6's Medication/Treatment/Therapy Management Plan did not include blood glucose monitoring and TED hose administration. R8 R8 began receiving services on December 30, 2020, under the comprehensive home care license and began receiving services under the assisted living licensure starting on August 1, 2021. R8's diagnoses included type 2 diabetes mellitus, macular degeneration, and chronic kidney disease. R8's service plan dated August 27, 2021, identified he received blood glucose testing. On June 7, 2022, at 6:30 a.m. ULP-D entered R8's apartment, administered oral medication and completed blood glucose testing. ULP-D assisted R8 with placing bilateral knee braces and getting dressed. R4's physicians orders signed on February 17, 2021, included an order for blood glucose monitoring, and a physician's order dated March 18, 2022, for bilateral knee braces on in the a.m. and off in the p.m. R8's Medication/Treatment/Therapy Management Plan dated August 20, 2021, failed to include the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 90 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. On June 9, 2022, at approximately 4:00 p.m. RN-B verified R8's Medication/Treatment/Therapy Management Plan did not contain the required information for blood glucose monitoring and knee braces. The licensee's Medication & Treatment - Administration & Delegation policy dated August 1, 2021, identified "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, Falls Landing Assisted Living will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." "Prior to a ULP providing delegated medication	01940		

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01940	Continued From page 91	01940		

administration and/or treatments/therapy, the following must occur:
1. A RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided.
2. [Facility name] will prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that will be provided to the resident.
3. The medications have current prescriber's orders on file.
4. A RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record.
5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them:
a) The complete procedure of checking a resident's medication administration record (MAR).
b) The preparation of medication for administration.
c) The administration of the medication to the resident.
d) The reminder to self-administer medications.
e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same.
6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN.
7. Written records, signed by a RN, shall be maintained regarding ULP training and

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01940	Continued From page 92 competency testing of delegated medication administration and treatment/therapy." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01940		
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure unlicensed personnel were trained and demonstrated competency in treatments to a registered nurse	01950		

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01950	Continued From page 93 (RN) for three of three unlicensed personnel (ULP-C, ULP-D and ULP-E) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-C ULP-C was hired on March 23, 2021, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-C began providing direct care and services under the assisted living licensure on August 1, 2021. On June 6, 2022, at 11:13 a.m. ULP-C stated she was trained by another ULP on how to administer medications. The nurse did not train or competency test her on medication administration, TED (thrombo embolic deterrent) hose (compression stockings used to increase vascularity and decrease swelling) placement, blood glucose monitoring or other delegated tasks. On June 6, 2022, at 11:16 a.m. ULP-C was observed administering medication to R7, and at 11:50 a.m. she administered medication to R4. R2's May 2022, Task Administration Record identified ULP-C had applied TED hose on May 4, 11, 18, 25, and 29, 2022.	01950		

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01950	Continued From page 94 R4's June 2022, Task Administration Record identified ULP-C had applied Tubi-Grip socks on June 1, 2022. R7's June 2022, Task Administration Record identified ULP-C had applied TED hose on June 1, 3 and 6, 2022. R8's June 2022, Task Administration Record identified ULP-C had performed blood glucose monitoring on June 1, 2022. ULP-C had placed bilateral knee braces on June 6, 2022. ULP-C's employee record lacked evidence training and competency testing was completed by an RN for TED hose, Tubi-Grip socks, blood glucose monitoring, or brace placement. ULP-D ULP- D was hired on June 11, 2018, to provide direct care and services to the licensee's residents under the comprehensive home care license. ULP-D began providing direct care and services under the assisted living licensure on August 1, 2021. On June 7, 2022, at approximately 6:40 a.m. ULP-D was observed administering medications, performing blood glucose monitoring, applying braces to bilateral knees, and assisting R8 with getting dressed. R2's May 2022, Task Administration Record identified ULP-D had applied TED hose on May 3, 8, 14, 15, 17, 22, 24, 2022. R4's June 2022, Task Administration Record identified ULP-D had applied Tubi-Grip socks on June 5 and 7, 2022.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30347	A. BUILDING: _____ B. WING _____	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01950	Continued From page 95 R8's June 2022, Task Administration Record identified ULP-D had performed blood glucose monitoring on June 5 and 7, 2022. ULP-D had placed bilateral knee braces on June 5 and 7, 2022 ULP-D's employee record lacked evidence training and competency testing was completed by an RN for TED hose, Tubi-Grip socks, blood glucose monitoring, or brace placement. ULP-E On June 8, 2022, at 6:41 a.m. ULP-E was observed supervising blood glucose monitoring and insulin administration for R5. ULP-E stated she was trained by another ULP for blood glucose monitoring and insulin administration. R7's June 2022, Task Administration Record identified ULP-E had applied TED hose on June 2 and 7, 2022. R8's June 2022, Task Administration Record identified ULP-E had placed bilateral knee braces on June 2, 2022. On June 6, 2022, at 3:52 p.m. RN-B stated she was working on forms for competency testing, but she had not implemented that yet. New staff completed an online training (Educare) and tested on that. Then they followed other ULP for a couple days. New staff were allowed to pass medications and perform other delegated tasks with the training ULP observing them. Then, staff could pass medications and perform other delegated tasks independently. RN-B was available to answer questions and occasionally would observe staff. She confirmed there was no formal training or competency testing completed	01950		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

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01950	Continued From page 96 by the RN. The licensee's Competency Training Evaluations policy dated August 1, 2021, identified "When a registered nurse or licensed health professional staff of [the facility] delegates tasks, prior to the delegation of services they must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks." "1. A Registered Nurse (or other licensed health professional where appropriate) will determine what nursing services may be delegated to properly trained and competency tested unlicensed personnel. 2. Only unlicensed personnel who are determined to be competent and possess the knowledge and skills consistent with the complexity of tasks being delegated will be permitted to perform such delegated tasks. 3. The Assisted Living facility will have a system in place to communicate up-to-date information to a RN regarding current available staff and their competencies. 4. Training and competency evaluations of ULP's will be conducted by a RN, or another instructor may provide the training in conjunction with a RN." 5. "Training and competency evaluation for unlicensed personnel providing assisted living services must include: g. Administering medications or treatments as required" No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01950		

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	30347	A. BUILDING: _____ B. WING _____	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a written prescriber's order for a treatment was obtained for two of five residents (R2 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving services on January 16, 2016, under the comprehensive home care license with diagnoses including vascular dementia, chronic obstructive pulmonary disease, and osteoarthritis. R2 began receiving services under the assisted living licensure starting on	01970		

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	30347	A. BUILDING: _____ B. WING _____	06/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FALLS LANDING ASSISTED LIVING	1101 NORTH HIAWATHA AVENUE PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01970	Continued From page 98 August 1, 2021. R2's service plan dated August 2, 2021, identified she received TED (thrombo embolic deterrent) hose (compressions stockings that increase vascularity and decrease swelling) assistance. R2's record lacked a physician's order for the treatment of TED hose. On June 9, 2022, at 9:52 a.m. registered nurse (RN)-B verified R2's physician's orders did not include an order for TED hose. R6 R6 began receiving services on December 1, 2021, with diagnoses including Alzheimer's disease, diabetes, bilateral lower extremity edema, and chronic obstructive pulmonary disease. R6's service plan dated December 3, 2021, identified R6 received assistance with blood glucose monitoring and TED hose administration. R6's 90 Day Assessment dated March 31, 2022, identified she received blood glucose testing. R6's medical record included a Continuity of Care Document (Ambulatory Clinical Summary) dated November 29, 2021, identified by RN-B to be physician's orders. The document included an order for blood glucose monitoring once daily and an order for compression stockings use as directed; however, the document lacked a physician's signature or electronic signature. On June 9, 2022, at 9:52 a.m. RN-B verified R6's physician's orders were not signed. She was unaware they did not contain an electronic	01970		

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01970	Continued From page 99 signature. The licensee's Medication & Treatment - Administration & Delegation policy dated August 1, 2021, identified "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, Falls Landing Assisted Living will ensure that the registered nurse has: 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." "Prior to a ULP providing delegated medication administration and/or treatments/therapy, the following must occur: 1. A RN must conduct a face-to-face resident assessment to determine what medication management or treatment/therapy services will be provided and how those services will be provided. 2. Falls Landing Assisted Living will prepare and include in the Service Plan a written statement of the medication management or treatment/therapy services that will be provided to the resident. 3. The medications have current prescriber's orders on file. 4. A RN must specify, in writing, specific instructions for each resident and document those instructions in the residents' record. 5. A RN must instruct the ULP on the following medication administration tasks before delegating the task to them:	01970		

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01970	Continued From page 100 a) The complete procedure of checking a resident's medication administration record (MAR). b) The preparation of medication for administration. c) The administration of the medication to the resident. d) The reminder to self-administer medications. e) The documentation after assistance with medication reminder or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with medication administration as ordered, and the initials of the nurse or authorized person who assisted or administered and observed the same. 6. The ULP must demonstrate their ability to competently follow the delegated medication administration or treatment/therapy to a RN. 7. Written records, signed by a RN, shall be maintained regarding ULP training and competency testing of delegated medication administration and treatment/therapy." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01970		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by:	02310		

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02310	Continued From page 101	02310		

Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with bilateral half siderails, with record reviewed. This resulted in an immediate correction order on June 6, 2022, at 10:00 a.m.

This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).

The findings include:

On June 6, 2022, at 11:16 a.m. surveyor observed bilateral half siderails on R2's bed.

R2's diagnosis included vascular dementia without behavioral disturbance, osteoarthritis of the knee, asthma, and fatigue.

R2's service plan dated August 2, 2021, indicated R2 received assistance with bathing, medication administration, and TED hose placement.

R2's "Side Rail/Assist Bar Evaluation Side Rail/Assist Bar Eval-Review" dated April 19, 2021, identified R2 used an assist bar. R2 had expressed a desire to have the assist bar. R2 used it for repositioning, getting in and out of bed and to promote independence. The assessment further identified R2 had a half siderail on the right side. The assessment failed to indicate R2's

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02310	Continued From page 102	02310		

bed had a half siderail on the left side. The assessment also failed to identify measurements for zones of entrapment, risks and benefits of siderails had been discussed with resident or family, and mitigation of risk had been attempted by the licensee.

On June 6, 2022, at 9:21 a.m. registered nurse (RN-B) stated that R2's bed had the siderails in place prior to start of her employment. She had asked R2 in the past if she wanted the siderails and if she used them. RN-B updated the assessment annually. RN-B further indicated being aware of the FDA Side Rail Entrapment Zones and Dimensional Recommendations; however, she had not measured the siderails. RN-B further confirmed the risks and benefits of side rail use had not been completed with the family or the resident, and no mitigation of risk had been attempted by the licensee.

On June 6, 2022, at approximately 9:30 a.m. RN-B completed measurements for R2's siderails with the surveyor present. The half siderails opening was found to be 4.5 inches wide between the bars and 17 inches high. The gap between the siderails and the headboard was 5 inches. In addition, under the bed, the siderail system was to be attached by two screws on each side of the bed. On the left side of the bed, one of the two screws was loose and not attached to the bed frame. This caused the side rail to be easily lifted up on that side of the bed, when lightly compressed the mattress to rail gap was greater then 4.75 inches. RN-B confirmed that it was possible for R2 to get entrapped within the openings.

The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations

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02310	Continued From page 103	02310		

indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches.

The Food and Drug Administration (FDA), "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."

The licensee's Side rails policy dated August 1, 2021, identified "When [licensee] is aware a home care resident is utilizing side rails (a medical device) on a bed, [licensee] will assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of side rails, and verify that the side rail in use is of a safe design and utilized consistent with the manufacturer's directions. This policy shall be followed regardless of who owns or is supplying the side rail."
"PROCEDURE-ASSESSMENT:
When side rails are in use, an RN must conduct an assessment to identify the intended purpose of the side rail and the risks regarding the use of the side rail. If the side rail is acting as a restraint, appropriate action should be taken."
"PROCEDURE-VERIFY THE MEDICAL DEVICE IS SAFE:
1. Staff from [licensee] will determine if the side rail is considered to be safe. "Safe" shall be

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02310	Continued From page 104 defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use. b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails. c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4. 75"." "PROCEDURE-EDUCATION: The resident and, when appropriate, the resident's representative, shall be informed of the risks and benefits regarding the use of side rails. Education provided will be documented in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE On June 8, 2022, at 4:02 p.m. the immediacy of correction order 2310 was removed; however, non-compliance remains at level 3, Isolated (G). TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/06/22*
Time: 10:55:17
Report: 1020221063

Food and Beverage Establishment Inspection Report

Location:
Falls Landing Assisted Living
1101 North Hiawatha Avenue
Pipestone, MN56164
Pipestone County, 59

Establishment Info:
ID #: 0038319
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 5075626648
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-703.11B ** Priority 1 **

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

HIGH TEMPERATURE DISHWASHER USED AT THE ESTABLISHMENT. PROVIDE AN IRREVERSIBLE TEMPERATURE INDICATOR TO ENSURE THE UTENSIL SURFACE TEMPERATURE REACHES 160F. EXAMPLES INCLUDE A MIN/MAX THERMOMETER, DISHTEMP, AND THERMOLABELS. USE MULTIPLE TIMES A WEEK.

Comply By: 06/24/22

4-100 Equipment Construction Materials

4-101.11BCDE

MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.

ICE CREAM BUCKET BEING RE-USED FOR FOOD STORAGE; USE FOOD GRADE FOOD STORAGE CONTAINERS TO STORE THE FOOD ITEMS IN THE ESTABLISHMENT.

Comply By: 06/07/22

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

SOME CABINET DOOR FINISHES ARE BEGINNING TO SEPARATE FROM THE DOOR EXPOSING THE BARE WOOD; REPAIR SO THE SURFACE IS SMOOTH AND NON-ABSORBENT.

Comply By: 09/30/22

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 PPM at Degrees Fahrenheit
Location: SANITIZER BUCKET
Violation Issued: No

Wash Temperature Gauge: = at 154 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Final Rinse Temperature Ga: = at 184 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Utensil Surface Temperatur: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - CHEST FREEZER, BACK STORAGE
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER, BACK STORAGE

Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: MILK - UPRIGHT COOLER, BACK STORAGE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: SWEET POTATOES - UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: CHICKEN AND SPINACH STUFFED SHELLS - WHITE UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: PASTA - SILVER UPRIGHT COOLER
Violation Issued: No

Type: Full
Date: *06/06/22*
Time: 10:55:17
Report: 1020221063
Falls Landing Assisted Living

Food and Beverage Establishment Inspection Report

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	2

GENERAL COMMENTS:

DISCUSSED COVID-19 AND EMPLOYEE ILLNESS POLICIES AND PROCEDURES. AN EMPLOYEE ILLNESS LOG AND ILLNESS REPORTING REQUIREMENTS FACT SHEET WAS PROVIDED WITH THE REPORT.

DISCUSSED COOLING AND RE-HEATING PROCEDURES. A FACT SHEET ON COOLING TIME/TEMPERATURE CONTROL FOR SAFETY FOODS AND A COOLING LOG WAS PROVIDED WITH THE REPORT.

A THERMOMETER CALIBRATION LOG WAS PROVIDED WITH THE REPORT.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1020221063 of 06/06/22.

Certified Food Protection Manager: Jennifer Currier

Certification Number: FM63285 Expires: 06/16/24

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221063

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pool, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975

No. of RF/PHI Categories Out	1	Date	06/06/22
No. of Repeat RF/PHI Categories Out	0	Time In	10:55:17
Legal Authority MN Rules Chapter 4626		Time Out	

	Address	City/State	Zip Code	Telephone
Falls Landing Assisted Living	1101 North Hiawatha Avenue	Pipestone, MN	56164	5075626648

License/Permit #	Permit Holder	Purpose of Inspection	Est Type	Risk Category
0038319		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47	X	Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) Report emailed **Date:** 06/13/22

Inspector (Signature)